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**BALANCING MEDICAL READINESS:
THE DILEMMA OF
CARETAKER HOSPITALS**

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BY

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As the United States Army shifts from a forward presence force to power projection force, the most challenging mission facing the Army Medical Department will be to maintain a medical force able to deploy in support of multiple contingency operations and continue to provide health care to Continental United States (CONUS) eligible beneficiaries. To answer this challenge, the Army Medical Department has developed the Caretaker Hospital concept. Under this program, active component hospitals remain in the force structure in a cadre status. The hospitals are at full authorized levels of organization (ALO) for equipment and very low ALO for personnel. They are reduced in full time manpower authorizations to a limited cadre with the residual health care staff assigned to a peacetime health care facility. The equipment is configured for long term, depot storage in order to ease deployment. This study examines the proposed operational concept and training plan for the Caretaker Hospital program.

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BALANCING MEDICAL READINESS: THE DILEMMA OF CARETAKER HOSPITALS

AN INDIVIDUAL STUDY PROJECT

by

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BALANCING MEDICAL READINESS: THE DILEMMA OF CARETAKER HOSPITALS

INTRODUCTION

The military health service system is embarked on a turbulent course, one heavily influenced by the many diverse and complex interests that are attendant to health care in the United States today. From the relatively short time I have been at the helm, there is no question in my mind that change is essential if we are to preserve military medicine and that coordinated care is the right course to achieve that goal.

Dr. Enrique Mendez Jr.¹

The disintegration of the Soviet Union, the downsizing of the Department of Defense and the shift from a North Atlantic Treaty Organization (NATO) focus to global Major Regional Contingency doctrine has dramatically affected the force structure of the Army. Reacting to both the dissolution of the Soviet state and explicit guidance from the Chairman, Joint Chiefs of Staff, the Army has significantly departed from the sequential, threat based steps of the Planning, Programming, Budgeting and Execution System (PPBES) and the Force Integration Process. The established Base Force and resultant support forces as reflected in Total Army Analysis, 1999 (TAA 99) is significantly smaller than previous force structures.

As the United States shifts from a forward presence force to a power projection force, the most challenging mission facing the Army Medical Department (AMEDD) will be to maintain a trained and ready, albeit, smaller medical force. A force able to both

deploy in support of multiple contingency corps and continue to provide care to Continental United States (CONUS) eligible beneficiaries. During Operations Desert Shield and Desert Storm (ODS) the precedent of maintaining existing peacetime levels of medical support to all eligible beneficiaries was established. As the United States Army Health Services Command (HSC) transitioned to war, continued care for CONUS beneficiaries during a major regional conflict proved possible and set the standard for the future.²

The challenge for the Army's medical leaders is to develop units that can rapidly mobilize and deploy to support combat operations within current manpower authorizations while continuing to provide day to day health services support. The establishment of the Caretaker Hospital program was initiated as a force structure enhancer. A Caretaker Hospital is an active component hospital assigned to the United States Army Forces Command. The hospital is manned at reduced personnel strengths but is fully equipped. The personnel who would normally be assigned to the unit are assigned to HSC so that they may provide health care to CONUS eligible beneficiaries. The equipment is maintained in deployment storage by a cadre staff to facilitate transition to war and overseas deployment.

The personnel resources required to implement the Caretaker Hospital program (as the remainder of the Army downsized) resulted from a congressional decision to protect the AMEDD force from personnel draw downs to levels less than FY 89 structure.³

The unit equipment became available by reinvesting the forward deployed hospital structure and equipment no longer required to support NATO. Combining this equipment with available personnel enabled the force programmers to capture eleven hospitals no longer required to support NATO under TAA 99 and earmark these units to support the forces required for executing multiple regional conflicts.

This force structure was re-flagged and repositioned in the United States Army Forces Command (FORSCOM) to support the three CONUS-based contingency corps. It is envisioned that nine of these hospitals will be resourced at very low authorization levels during peacetime with a core of essential/caretaker personnel.⁴ These hospitals are referred to as the Caretaker Hospitals. Due to the very fluid changes in the total force structure expected as a result of the 1992 United States presidential election, an exact number of caretaker hospitals is still to be determined.

Regardless of the final numbers of Caretaker Hospitals, a shift to a CONUS based power projection Army, implementation of lessons learned from Operation Desert Storm, and the real fiscal pressures affecting the delivery of peacetime health care will necessitate dramatic changes for the AMEDD. The implementation of the operational concept for Caretaker Hospitals will prove to be a challenge for both FORSCOM and HSC. The addition of Caretaker Hospitals to the structure may prove to be a force multiplier or may become an unnecessary drain on this nation's

scarce military resources. The answer to this dilemma is to ensure that the personnel assigned to the Caretaker Hospitals are trained and ready, able to deploy in support of a power projection army. This paper will examine the proposed operational concept and training plans for the Caretaker Hospitals.

THE DILEMMA

If one has never personally experienced war, one cannot understand in what difficulties constantly mentioned really consist, nor why a commander should need any brilliance and exceptional ability. Everything looks simple; the knowledge required does not look remarkable, the strategic options are so obvious that by comparison the simplest problem of higher mathematics has an impressive scientific dignity. Once war has actually been seen the difficulties become clear; but it is still extremely hard to describe the unseen, all-pervading element that brings about this change of perspective.

Carl Von Clausewitz⁵

The key combat service support unit for providing medical support to a theater is the hospital. The number and types of hospitals beds supporting a combat commander is the focal point for medical operations in a campaign.⁶ From the early beginnings of modern medical support, the use of hospitals as far forward to the front lines has been paramount in United States Army medical doctrine. The current medical doctrine, Medical Force Two Thousand (MF2K), relies on the twin pillars of hospitalization and evacuation. The hospitalization force is

comprised of Deployable Medical Systems (DEPMEDS) hospitals of various sizes and capabilities able to deploy and relocate within any theater of operations. The DEPMEDS MF2K hospitals are designed to support a NATO warfight.⁷

The DEPMEDS Table of Organization and Equipment (TO&E) hospitals units are apportioned to a warfighting Commander-in-Chief (CINC) as part of the Special Theater Forces or are forward deployed. As the Army reduces its forward presence, the Army will rely heavily upon hospitals that can rapidly deploy from CONUS to support multiple major or lesser regional contingencies. The United States Army Forces Command will be the supporting CINC and provide hospital forces to the combatant CINC.⁸

The primary United States Army major command responsible for providing critical medical manpower and for providing peacetime health care to eligible Department of Defense beneficiaries in the Continental United States (CONUS) is the United States Army Health Services Command (HSC). The fixed Table of Distribution and Allowances (TDA) hospitals in Health Services Command are also the primary source of trained medical personnel for deploying and forward deployed TO&E medical and non-medical units.⁹ Recognized by Army Regulation 601-142, the Professional Officer Filler System (PROFIS) serves as a unique manpower resourcing system for the Army. During peace, a soldier performs patient care in a medical treatment facility and is assigned against a TDA requirement and authorization. During transition to war, the same soldier deploys to fill a TO&E unit

requirement.¹⁰ The Army Medical Department relies heavily on PROFIS to continually balance the pressures of medical readiness for the Table of Organization and Equipment (TO&E) force and the peacetime health care delivery mission of the fixed facility TDA force.

The dilemma of readiness and health care continues to plague AMEDD leadership. Any system that fragments resources and gives one commander the ability to prioritize missions and the other commander the ability to allocate resources creates conflict. Previous attempts to resolve these conflicts have been addressed by several programs and initiatives developed in the 1970s and 1980s. These programs had the same goal: maximize the time available for the maximum number of critical health care providers to perform hands-on patient care. Subsets of this goal included the investment in combat training only to a core of key active duty personnel and the reliance on the reserve components to backfill PROFIS losses.

In the late 1970's Major General William P. Winkler, Jr., proposed the Carve/Merge Concept as an initiative to enhance AMEDD readiness. This concept was the first formal attempt at capturing and converting TDA structure into TO&E requirements. Although this concept was not implemented by the Army staff, the program validated several operational requirements. The Carve/Merge concept led to the development of the Korea Medical Augmentation Package (K-MAP). The K-MAP plan is the first AMEDD initiative that formally recognized Health Services Command as a

manpower pool for supporting and supported CINCs. In 1988, Lieutenant General Frank F. Ledford, The Surgeon General of the Army, acted on a readiness initiative of the 7th Medical Command, United States Army, Europe (USAREUR) by creating a Medical Rapid Reinforcement (MRR) force. The principles of the K-MAP were incorporated into the MRR concept. Unlike the K-MAP, the MRR concept evolved into a formal Memorandum of Understanding between Health Services Command, Forces Command and USAREUR. Additionally, the MRR concept formalized and documented the reserve component requirement for the backfill mission of mobilization Troop Program Unit.¹¹

The Carve/Merge, K-MAP and The Medical Rapid Reinforcement plans relied on similar base assumptions and employment concepts. These concepts included: an equipped field (TO&E) hospital maintained by a low resourced core of active duty personnel; an identified fixed facility from where the key and essential medical nucleus of the force is deployed; reliance on PROFIS for the remainder of the TO&E fill to cover shortages or military occupational skill (MOS) mismatches; a formal deployment training plan; and use of the reserve components for residual and backfill of CONUS health care needs. These employment concepts are applicable to the Caretaker Hospital program.

For the remainder of the 1990's and well into the 21st century, the AMEDD will be forced to employ all available methods of force accounting to balance the AMEDD structure, maintain peacetime levels of healthcare and enhance combat readiness. An

extensive use and mixing of low authorized level of organization (ALO) TO&E units, TDA hospitals, Mobilization TDA (MOBTDA's), Reserve Component Troop Program Units and Individual Mobilization Augmentees (IMA) must be employed in a coordinated effort.¹²

The Caretaker Hospital operational concept requires separate chains of command to be responsible for the readiness and training. Because the major commands (HSC and FORSCOM) impacting on the Caretaker Hospital concept are involved in distinctly different missions with different priorities, the problems which plagued the AMEDD during Operations Desert Shield and Storm may be repeated. One commander concerns himself with medical proficiency training and with the efficiencies of providing cost effective peacetime health care. The other commander concerns himself with training and deploying the force. For the Caretaker Hospital system to be effective, a significant investment in training and staff coordination will be required.

Field Manual 100-1 states that training is both an intellectual and physical process. The intellect and the body must be trained but neither is of benefit when the moral commitment and discipline of spirit to understand the purpose and necessity of training and consequent right actions are absent.¹³ Neither HSC or FORSCOM have the same purpose or commitment to training. Any system that formally fragments the personnel training from the training resources will fail to achieve its stated goals.

CARETAKER HOSPITAL OPERATIONAL CONCEPT

In addition, a lessons learned report stated that during Operation Desert Shield/Storm, some key personnel working in medical treatment facilities had been removed from PROFIS slots when the deployment of units had been initiated. It is said that these actions had been taken to preserve continuity within continental U.S. Army medical treatment facilities.

GAO/NSIAD report¹⁴

Although the organizational and operational concept of the Caretaker Hospital (CTH) is still not finalized, by design, the CTH is an active duty unit. Once deployed the CTH is expected to provide the same levels of medical support as a fully staffed FORSCOM hospital. The goal of the CTH program is to provide a framework from which a hospital infrastructure can rapidly be projected to a maturing theater. To achieve this goal, the concept requires that the hospital be in a state of equipment preparedness and personnel readiness comparable with similar reserve component hospital. However for the concept to be effective, the CTH must not be subject to the deployment restrictions imposed by law on the reserve components.

CTH readiness is maintained to the same standard of other active duty FORSCOM medical units. The Commander, Forces Command, has directed that the Caretaker Hospitals must train as a unit with at least the frequency of training of the Reserve Component to attain the expected deployment preparedness.¹⁵

This training standard keeps the Caretaker Hospitals readiness in concert with Department of Defense guidance. This guidance mandates that Reserve Component forces that are deployed or employed in association with active forces will have priority for readiness equal to their associated active units and will achieve the same readiness as training availability allows.¹⁶

Equipment readiness and deployability is achieved by maintaining the majority of the CTH equipment in depot pack for overseas shipment. To train the CTH staff on unit equipment, an additional DEPMEDS Minimal Essential Equipment for Training (MEET) set is authorized. The MEET set is designed and tailored for sustainment training on individual, crew and section level combat critical tasks. It is not to be used for local garrison and training area usage and will not be used for local site medical support.¹⁷ Because the majority of the unit equipment is in long term storage and will remain in depot pack for rapid movement to port, personnel authorizations are reduced to a cadre of administration, medical and maintenance personnel. Vehicles, generators and other select associated items of equipment will not be placed in long term storage but will be maintained in accordance with current maintenance criteria by the cadre.

In addition to maintaining unit equipment, the cadre serves as the reception staff required for personnel assignment during unit transition to war procedures. CTH cadre commanders are responsible for the individual training of soldiers permanently assigned to the CTH. The commander is also responsible for the

planning, coordination and execution of collective training for the entire organization.¹⁸

The Caretaker Hospital cadre staff is reinforced by key personnel from a designated medical treatment facility (MTF). These key personnel include the designated wartime commander and chief nurse and serve as the nucleus for the professional medical staff of the Caretaker hospital. Whenever possible the MTF is co-located at the same post. The remainder of the personnel requirements are filled through a proposed Medical Filler System (MEDFIS). MTF commanders are responsible for the individual training for key personnel and MEDFIS personnel.¹⁹

For the conduct of collective training, the unit is fielded an additional MEET set and aligned with a regional medical treatment facility. The CTH cadre (as documented by the MTOE) and the MTF key personnel (as determined by the local MTF commander) undergo a ten day New Equipment Training (NET) process. After NET training is accomplished, the CTH and MTF commanders develop an annual Mission Training Plan which culminates in a two week annual training exercise at a Regional Training Site (RTS-MED). Additionally, every two years the CTH will undergo an Army Training and Evaluation Program (ARTEP) by the higher headquarters.

To support the operational concept, proposed training plans and strategies have been developed by Health Services Command, Forces Command and the AMEDD center and School. This training proposal covers equipment, tasks and an annual training calendar.

Examination of the training plan reveals that the principles of training as defined by the Army in FM 25-101, Battle Focused Training, are not incorporated. The training plan was to developed to serve as an exportable AMEDD Center and School program of instruction.²⁰ It is not Battle focused nor developed from an approved Mission essential Task List.

The disconnect is readily apparent when the proposed training program of instruction is matched with the deployment sequence developed by a battle focused staff. The 1st Medical Group stationed at Ft Hood, Texas is converting several units to caretaker status. The group is the first FORSCOM major medical organization to accept CTH units and the 1st Medical Group staff is operationally focused. The medical group and the CTH unit accounts for filler personnel using the provisions of AR 220-1 and assesses the total personnel readiness. After completion of unit NET training, the CTH hospital commanders determines the minimum proficiency or days of training required to maintain combat readiness. In accordance with AR 220-1, the unit has achieved an acceptable level combat readiness and is deployable after completion of the required days of training.²¹

The unit collective training is planned to meet a deployment scenario consistent with a major regional contingency. The training is battle focused and sequential. A generic deployment sequence using a commencement date for reinforcement (C-date) serves as the employment concept. The CTH is alerted for deployment. The cadre staff begins the initial operations

required to move equipment to the port of debarkation (C-DAY). The CTH cadre, the MTF key personnel and local MEDFIS personnel assemble to formulate operation plans and prepare movement to port (C+1). The manpower and vehicle operators required to move equipment to port is now available from the MTF and the unit is moved to port (C+15). Equipment is moved to theater via sealift arriving in accordance with the required arrival date (C+30).

Concurrently, the MTF commander follows a parallel plan. The MTF is initially backfilled by reserve component Individual Mobilization Augmentees (IMA) to continue to provide local health services to eligible beneficiaries. The MTF Mobilization Table of Distribution and Allowances (MOBTDA) and the Troop Program Unit (TPU) is immediately activated. All sources of reserve personnel required by the MTF to continue the CONUS mobilization mission report for duty (C+14).

Continuing the deployment sequence, the CTH main body is resourced to full TO&E levels by MEDFIS, PROFIS and selected IMA. All personnel undergo required deployment training and process for overseas replacement (POR). After completion of POR and unit training, non-critical personnel return to the MTF to continue to provide local health services (C+15 to C+30). The unit advance party departs for theater (C+20) and the remaining CTH personnel are deployed to theater via airlift to arrive in theater on or about the time equipment arrives.

In theater, the entire personnel compliment meets in a staging area to deploy to unit assembly area or battle position

where the equipment is unpacked and reconfigured from depot pack to a medically functional pack. The hospital is established (C+52) and is fully functional by C+60.

A careful review of the above proposal reveals a lot of hard work by dedicated field personnel focused on medical operations.²² Unfortunately all efforts are focused at individual tasks, conditions and standards and operational concepts which are already well established and documented. Little effort has been devoted to changing the systems, organizations and policies which will allow execution of the Caretaker Hospital concept.

Without dramatic systemic changes, the training tasks required for unit operations will be impossible to execute. The time required to be minimally operationally proficient and the recurring training necessary to serve as the building blocks for collective training is resisted by the fixed health care providers. The key personnel necessary for planning and executing the training face real conflicting priorities and scarce resources.²³

Succinctly stated, the pressures of delivering peacetime health care facing a MTF commander and the readiness and deployability requirements of the CTH commander are diametrically opposed. Furthermore, the coordination of resources required to execute the deployment time-line does not rest in a single organization or command. The only approach to ensuring that the caretaker hospitals are trained in deployment, trained in

employment of a combat hospital and can meet a realistic time line is to completely empower a single organization with the mission. The medical paradigm must be broken and a new approach to how the AMEDD transitions to war must be developed.

FORCES PREVENTING SUCCESS

An additional training shortfall identified by active duty hospital personnel during our review was that some unit commanders had no experience in commanding units and had not participated in any of the training for the units they were to command. In peacetime, hospital units are commanded by medical service corps officers, who are responsible for the day-to-day operations of the unit. The Army has determined, however, that upon being alerted to deploy, a hospital unit must be commanded by a physician. Army after-action reports identified this situation as a problem and reported that in some cases it had adversely affected unit mission capability.

GAO/NSIAD report²⁴

Although the Caretaker Hospital proposal appears to have promise as a means of maintaining health care and readiness for the AMEDD, recent experience tends to refute the viability of the concept. Without diminishing the successes of Operation Desert Storm, serious medical operational and training deficiencies were identified. Overall, the AMEDD medical effort was successful. The medical units of the XVIII Airborne Corps were well prepared; however, the medical units assigned to VII Corps and Echelon Above Corps (EAC) were not as successful.²⁵

The overwhelming reason for the success of the XVIII

Airborne Corps hospital units can be traced to a single common denominator. The majority of the corps' medical and hospital units were active duty units belonging to Forces Command. Analyzing the hospitals of the XVIII Airborne Corps against those of VII Corps and those assigned to echelons above corps, gives the AMEDD planner insight to weakness of the employment concept and expectations of the CTH. The XVIII Airborne Corps hospitals were primarily active duty units whose full time job was to prepare for combat and had three to four months in theater to train for their imminent combat missions.²⁶ The majority of the remaining VII Corps and EAC theater hospitals came from the Reserve Components who had limited deployment and training opportunity.

Further comparison reveals that the Active Component hospitals which deployed from Europe were normally manned at low authorized levels of organization (ALOs) by United States Army, Europe (USAREUR) as a matter of routine. Based upon a NATO scenario, USAREUR medical planners felt that sufficient early warning was available to transition to war and a low ALO was an acceptable risk. Once deployed the units found themselves away from their NATO focus and General Defensive Position orientation; and, the command group had to be creative in restructuring their organizations to meet new requirements.²⁷

The same turbulence and problems created by the massive influx of enlisted personnel replacements of critical military occupational specialties as well as the influx of officers from

the PROFIS f'll as experienced by VII corps hospitals must be anticipated in the CTH concept. It is now recognized by the AMEDD that deploying hospitals at low ALOs then filling them with Active Component and Reserve Component personnel caused unity readiness and identity problems.²⁸

The XVIII Airborne Corps transitioned to war with a nucleus of active duty key leaders, both officer and non-commissioned officers. The full time assignment of a Lieutenant Colonel, Medical Service Corps commander and staff charged with the peacetime training and sustainment of the unit in CONUS was invaluable. The leadership, technical skills and medical experience of the senior non-commissioned officers permanently assigned to the unit cannot be understated. The leaders were tactically proficient.

An additional factor which enabled success was extensive equipment knowledge by XVIII PROFIS personnel. The majority of full time hospital personnel were well trained on their equipment and technically proficient. The hospitals which had the training time in CONUS, training time in theater or routinely engaged in major corps level exercises were able to maneuver and adapt medical support to the combat commander's intent. Those units which did not routinely employ the majority of its equipment were not as successful. A VII Corps after-action report revealed an embarrassing lack of field training resulting in a lack of basic soldering skills and unfamiliarity with their units mission of field equipment.²⁹

Finally, the deployment training opportunities available to FORSCOM hospitals proved invaluable. A unit's participation in a Return of Forces to Germany (REFORGER) exercise or support to the deployment engineer units in United States Southern Command (SOUTHCOM) nation building efforts enhanced unit flexibility.³⁰ The units were able to adapt to different missions. Neither the proposed training plan of the CTH nor MTF place emphasis on the requirement for deployment training. The training of junior leaders in the deployment procedures and actual participation in these deployments is invaluable in the professional development of future commanders.

A SOLUTION

A well-trained, well-led military force will develop pride and esprit de corps. From esprit de corps come cohesion and bonding. Leaders foster cohesion by ensuring that soldiers understand the unit's mission and its importance to national defense. Leaders establish strong bonding with those entrusted to them by setting personal and professional examples of excellence and by unequivocal demonstration of their own commitment, competence, candor and courage.

FM 25-100³¹

The Caretaker Hospitals present the Army Medical Department unique challenges. The Army staff expects the AMEDD to act as a corporate body to implement solutions to these challenges. Five systemic, institutional issues must be addressed and overcome to ensure that the Caretaker Hospital concept is viable. These issues are: the establishment of a single chain of command; the

development of permanent officer and enlisted manning system; the establishment of CONUS system responsible for the maintenance of deployable medical systems; the conduct of field medical training; and the integration Reserve Component Troop Program Units and Individual Mobilization Augmentees into Health Service Command.

The first issue, a single chain of command empowering a commander with the mission, resources and requirement to be ready to go to war is the foundation for success. Without a single commander, the other issues cannot be accomplished. Field Manual 25-100 states that commanders are the primary trainers of the force. Commanders base training on wartime mission requirements; identify applicable Army standards; assess current levels of proficiency; provide the required resources and develop; and execute the training plan.³² The logical command to which the key components of a Caretaker Hospitals must be consolidated and assigned is the United States Army Health Services Command.

The Army Plan gives the AMEDD leadership specific guidance. The force must structure and utilize both peacetime and wartime medical assets to provide comprehensive and cost effective health care. No growth in medical endstrength can be assumed.³³ To ensure a trained and ready medical force, able to deploy as well as continue to provide quality medical care, requires a significant departure from the Army's current AMEDD alignment. Therefore, the Surgeon General of the Army must be the primary medical manager for all health services in the Continental United

States.

On 7 April 1992, a proposal to create A United States Army Medical Command (USAMEDCOM) was approved on a provisional basis by the Assistant Secretary of the Army for Installations, Logistics, and Environment [ASA(IL&E)]. The purpose of the concept is to recognize the Surgeon General as the overall manager of the Army Medical Department and empower him with the overall command responsibility for health care delivery.³⁴ The creation of a CONUS Medical Command is the catalyst which will enable the Caretaker Hospital concept to succeed. For the Caretaker Hospital concept to be effective, the Surgeon General of the Army must assume command of all fixed medical assets and caretaker units within the continental United States.

When the ASA(IL&E) directive is fully implemented, The Surgeon General becomes the Army's overall medical commander. The United States Army Health Services Command will no longer be a Department of the Army major command and will be redesignated a major subordinate command within USAMEDCOM. The current fixed medical system of regionalization under Health Services Command will remain in effect and the regional medical centers will continue to report to Health Services Command. The smaller medical department activities, in turn, report to the regional MEDCENS.³⁵ As currently envisioned by the operations concept, the Caretaker Hospital continue to be aligned against the local medical treatment facility. A single command structure responsible for training, equipping and mobilization of both

fixed and deploying units will be more efficient.

The rationale used for the creation of a USAMEDCOM is applicable to the Caretaker Hospital concept. The rationale for both tangible and intangible improvements for the Army include the establishment of a single management framework which is responsible and accountable for the Army medical mission; a single organization capable of management of change for the transition of Army Health Care into a more business-like mode of operation while achieving management efficiencies and maximum operational effectiveness; enhanced medical planning, programming and budgeting; and improved planning, coordination and integration on issues impacting on wartime readiness and peacetime health care.³⁶

Once a single command is responsible for the CTH, the second institutional issue, the source of the medical personnel, can be addressed. A manpower system will continue to be required to overcome TDA/TOE mismatch and maintain the required specialty mix for peacetime health delivery within the endstrength and skills for the AMEDD mission. Currently, the PROFIS system applies to AMEDD officers and does not address all medical skill mismatches. Furthermore, the establishment and recognition of enlisted fillers as defined by MEDFIS is informal. There are no regulations or policies that formalize MEDFIS. The AMEDD must use the manning principles established in PROFIS to develop a total force regimental system.

Today's Army's regimental system is not a manning system.

It was designed to create cohesion in spite of the personnel manning system.³⁷ Under the Army's regimental system, all AMEDD personnel are members of a single AMEDD Regiment. A new medical regimental system based upon the HSC Medical Centers regional system needs to be created to serve as a manning system. This new system, if properly implemented, would form the framework for the PROFIS/MEDFIS system. The regional regiment would be responsible for manning the Caretaker Hospital. Additionally, the regiment would serve as the primary source of manpower for all deploying non-medical units (divisions, brigades, etc.) which have requirements but limited authorizations for medical personnel.

Refinement of the regimental system would eliminate the need for similar redundant programs such as the K-MAP or the MRR program. For example, with a new regimental system serving as a manning system, affiliation with a regional medical center regiment would occur upon completion of a soldier's initial military occupational skills (MOS) training. Within the region the soldier could be assigned to any of the FORSCOM TOE units, HSC TDA units or a Caretaker Hospital. His primary daily duties could be with his unit of assignment but his mobilization role would be with the regiment.³⁸ By mandating wear of the regimental crest, instant unit recognition and initial squad or team building within fixed hospitals would begin. The establishment of a single permanent regimental system would eventually result in the elimination of the PROFIS/MEDFIS systems

and establish permanence within the AMEDD for active and reserve component soldiers.

After the command and personnel issues are resolved, the equipment operational concept needs to be re-addressed. The manpower levels associated with a Caretaker Hospital and the configuration of the unit in long-term storage does not allow for realistic deployment abilities. The Caretaker Hospital operational concept must be changed to allow for operational deployment training and long-term storage. A solution that has proven very successful is the Army's Prepositioned Material Configured to Unit Sets (POMCUS) program. The establishment of similar regional POMCUS sites for the Caretaker Hospital at current depots or at select Reserve Training-Medical (RTS-MED) Sites is required for a successful CTH program. Site visits, POMCUS draw programs and manning systems similar to those in place at Army Combat Equipment Group, Europe (CEGE) sites could easily be adaptable to the Caretaker Hospital concept.³⁹ Caretaker POMCUS sites would eliminate a myriad of maintenance problems associated with unit responsibilities for long-term storage. By co-locating several CTH unit sets in a medical POMCUS site, manpower savings based on economies of scales and civilianization of military maintainer appear self-evident. A reduced requirement in the Caretaker Hospital cadre authorization is possible. The management of TOE changes and changes to unit assemblages and medical equipment sets could be applied at the depot level.

The POMCUS maintenance standards of 95% preventive maintenance checks accomplished and 100% property accountability could be easily achieved by depots.⁴⁰ It is doubtful that storage of Caretaker Hospitals by reduced cadre personnel could achieve the same standards.

The establishment of a single commander and stove pipe chain of command, a formal manpower pool and a central equipment site facilitates an operationally focused, executable training program. The training program begins with a single commander determining the Mission Essential Task List and required training cycle. An effective caretaker hospital training plan must include an external training program which culminates in an external evaluation (ARTEP) every two years. The training must be planned to support the field as well as compliment the medical tasks.

Initial training that would have minimal impact on the peacetime health care delivery system would be quarterly field training. However, instead of the hospital going to the field, the field goes to the hospital. The medical skills training is accomplished by co-locating the MEET set next to the fixed facility. The patient flow is re-routed from the fixed facility into the field hospital. The delivery of peacetime health care is minimal interrupted. The professional medical staff performs patient care with the equipment they are required to use on a unit deployment and the benefits of team and squad building are self-evident. As a by product of hands-on training, a

professional evaluation of medical equipment is accomplished by the actual users. The results of the professional evaluation is used for the DEPMEDS Product Improvement Program (PIP).

The next training step is the conduct of collective training that is battle focused. This training is mandated for all personnel assigned to a Caretaker Hospital. All TDA personnel engaged in peacetime health care are required to adjust their workload to meet this training requirement. The cadre, the core and selected regimental fillers deploy biennial in a given month to an RTS-MED site to form into their unit and execute collective training.

Because battle focused training is based on wartime requirements, it is recognized that Army units cannot achieve or sustain proficiency on every possible task. The deployment to an RTS-MED site allows the commander to focus on those tasks which are essential to the wartime mission and the development of the Mission Essential Task Lists (METL).⁴¹ The concentration of the commander and his staff in an environment free of external peacetime health care pressures facilitates the analysis of the METL.

The METL leads to an assessment which results in the commander's training guidance. The guidance serves as the catalyst for the development of training plans. It serves as the basis for current training execution and the development of the Long Range Training plan for the next biennial cycle.⁴²

At the present time the AMEDD professional fillers rarely

conduct battle focused training. Key hospital personnel are required for the daily mission execution of the local medical facility. The temporary shortfall in manpower available for health care delivery created by training can be overcome. By cross-leveling on a temporary duty status within the medical center region or regiment; by making available to the reserve component IRR or IMA additional training periods; or by scheduling in two-week increments the Reserve Component Troop Program Units Annual Training (AT) period the patient care disruptions can be minimized. Additionally, careful management of appointments, elective procedures and other methods of curtailment of non-emergency services once every two years cannot be considered an unreasonable nor an unnecessary disruption of care to eligible health care beneficiaries.

The Troop Program Unit and individual reserve personnel required to fulfill the classical Health Service Command missions of providing health services and personnel to deploying forces and expansion of hospital bed capability within the CONUS sustaining base needs to be fully identified. Once identified, the incorporation of the CTH training and operational concept will serve as a key step toward the validation of the continuity of health service support operations. The Chief of Staff of the Army intends to use the Louisiana Maneuvers as the Army's program to bring together and focus the forces of change as the Army transitions to a CONUS based force.⁴³ The validation of the AMEDD's transition to war policies, the caretaker hospitals and

the professional officer filler system is the Army's number two Louisiana Maneuver issue.⁴⁴

The Caretaker Hospital concept cannot succeed until the fifth major institutional challenge is resolved. Because the incorporation of the Reserve Component resources into the training and deployment plan of a caretaker hospital is critical for readiness and for providing peacetime healthcare, a single commander must be control both systems. Currently, the management of the Troop Program Units is the responsibility of Forces Command. The structure and organizational location of AMEDD United States Army Reserve TDA units does not support the medical wartime mission. These units are structured as independent organizations and in peacetime are in the ARCOM/CONUSA FORSCOM chain of command.⁴⁵ After transition to war, these units are used to augment Health Services Command.

The transition from FORSCOM to HSC and back is often unwieldy, inefficient and time-consuming.⁴⁶ As a result of the command alignment, the Health Services Command has no means of managing TPU unit readiness nor affect training priorities. Additionally, Health Services Command has no incentive to apply resources to improve TPU training and FORSCOM has no incentive to facilitate peacetime health care delivery. The Reserve Component assets designated as CONUS backfill or mobilization expansion resources for Health Services Command must be placed under the Surgeon General of the Army in his role as Commander, United States Army Medical Command.

EPILOGUE

The Caretaker Hospital concept needs further study to assess the costs and benefits for the Army. The balance between readiness and healthcare is a difficult issue. It is safe to say that if the AMEDD resources required for war and peace do not come together or the personnel empowered to make training a priority do not support dramatic changes, the Army field medical system may be at risk.

Clausewitz writes that in a sense the order of battle consists of an arithmetical and geometrical component: organization and disposition. The former emanates from the army's normal organization in peace which serves as building blocks for larger structures, which in turn form the whole depending on the requirements of the moment. Similarly, the army's disposition starts from the basic tactics in which it has been instructed and trained in time of peace - characteristics not subject to basic change once war is broken out.⁴⁷

In modern times, the Army Medical Department has been forced to change its disposition from warfighting to peacetime health care. The paradigm of the medical force will continue to be to conserve the fighting strength by providing quality peacetime health care first and wartime readiness training second. The danger comes when, in the next war, the basic characteristic of the medical force is fixed hospital care. The effectiveness of the force structure organization (arithmetical component) is

overcome by the lack of training (geometrical component). The system will, by default, be able to provide timely combat support only to a small force. The proper employment and training of the Caretaker Hospital can serve to instill a warfighting focus and enhance the geometrical component of the expected limited TO&E force structure Army Medical Department remaining in the post cold war Army.

ENDNOTES

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² Roger Foxhall, "Mobilization Mission Drivers for Health Services Command," Concept Paper for The Surgeon General, Washington, 15 July 1991, 1.

³ U.S. Department of Defense, Manpower Requirements Report (Washington: U.S. Department of Defense, 1993): III-5.

⁴Larry Denard, interview by author, 16 September 1992, Washington, D.C. Handwritten notes.

⁵Carl Von Clausewitz, On War, trans. Michael Howard and Peter Paret (Princeton: Princeton University Press, 1989), 119.

⁶The Joint Chiefs of Staff, Doctrine for Health Service Support in Joint Operations, Joint Publication 4-02 (Washington: The Joint Chiefs of Staff, 20 August 1991), II-8.

⁷John M. Bull, "Medical Care for Echelons Above Divisions - Is Medical Force 2000 Adequate to Need?," U.S. Army War College Military Studies Project (Carlisle Barracks, PA, 1992), 28.

⁸ Charles S. Rousek, ed., Army Command Leadership and Management: Theory and Practice (Carlisle, PA: US Army War College, 1992), 10-18.

⁹Foxhall, 2.

¹⁰Ibid.

¹¹Denard.

¹²Foxhall, 3.

¹³Department of the Army, The Army, Field Manual 100-1 (Washington: U.S. Department of the Army, 10 December 1991, 13.

¹⁴U.S. General Accounting Office, GAO/NSIAD 92-174, Operation Desert Storm - Full Medical Capability Not Achieved (Washington: U.S. General Accounting Office, August 1992), 20.

¹⁵David B. McCrady, LTC, USA, interview by author, 19 January 1993, Washington D.C. Handwritten notes.

¹⁶Department of Defense, Defense Planning Guidance FY 1994-1999(U), (Washington: U.S. Department of Defense, 22 May 1992), 38.

¹⁷Charles T. Cahill, interview by author, 20 October 1992, Fort Sam Houston, Texas. Handwritten notes.

¹⁸Ibid.

¹⁹Ibid.

²⁰Marshall S. Scantlin, COL, USA, interview by author, 4 March 1993, Fort Sam Houston, Texas. Handwritten notes.

²¹Department of the Army, Unit Status Report, Army Regulation 220-1 (Washington: U.S. Department of the Army, 1 May 1992), 11.

²²Darwin Odom, MAJ, USA, interviewed by author, 19 October 1992, Ft Hood, Texas. Handwritten notes.

²³David McCrady, "Trip Report - Caretaker Hospital Concept Plan," memorandum for Director of Health Care Operations, Washington, 7 December 1992.

²⁴GAO/NSIAD 92-175, 28.

²⁵GAO/NSIAD 92-175, p. 44.

²⁶Jeanne H. Chudy, "A Study to Determine a Training Plan for Caretaker Hospitals" Webster University Graduate Research Project (San Antonio, TX, 1992), 18.

²⁷GAO/NSIAD 92-175, 44.

²⁸William L. Moore, Jr., "Operation Desert Shield/Storm AMEDD lessons Learned," memorandum for Office of the Surgeon General, Fort Sam Houston, 16 June 1992.

²⁹GAO/NSIAD 92-175, 27.

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³¹Department of the Army, The Army, Field Manual 100-1 (Washington: U.S. Department of the Army, 10 December 1991), 17.

³²Department of the Army, Training the Force, Field Manual 25-100 (Washington: U.S. Department of the Army, November 1988), 1-5.

³³Department of the Army, The Army Plan FY 1994-2009(U), (Washington: U.S. Department of the Army, 10 October 199), 57.

³⁴Ronald R. Blank, "Concept Plan for Establishment of the US Army Medical Command (Provisional)," memorandum for Division Chiefs, Professional Services Directorate, Washington, 23 September 1992.

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³⁶Blank.

³⁷Lewis W. McKenzie, "The United States Army Regimental System - A Panacea?," U.S. Army War College Military Studies Project (Carlisle Barracks, PA, 1983): 7.

³⁸Michael S. Robertson, "The Regimental System A Framework for Better Force Structure and Stationing Decisions," U.S. Army War College Military Studies Project (Carlisle Barracks, PA, 1986), 14.

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⁴⁰Ibid.

⁴¹Department of the Army, Training the Force, Field Manual 25-100 (Washington: U.S. Department of the Army, November 1988), 2-4.

⁴²Department of the Army, Battle Focused Training, Field Manual 25-101 (Washington: U.S. Department of the Army, 30 September 1990), 3-2.

⁴³Gordon R. Sullivan, "Letter of Instruction for Louisiana Maneuvers (LAM)," memorandum for BG Tommy R. Franks, Director, Louisiana Maneuvers Task Force, Washington, 22 May 1992.

⁴⁴Melinda Deffer, MAJ, USA, interview by author, 19 January 1993, Washington D.C. Handwritten notes.

⁴⁵Moore.

⁴⁶Ibid.

⁴⁷Clausewitz, 292.

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